North Carolina Medicaid Special Bulletin

An information service of the Division of Medical Assistance

Please visit our website at [www.dhhs.state.nc.us/dma.](http://www.dhhs.state.nc.us/dma)

January **2006**

Attention:

All Providers of Enhanced Benefit Mental Health /Substance Abuse Services Phase II

***PLEASE NOTE:** Only the following services are going to be discussed in the January seminar:

Child and Adolescent Day Treatment (MH/SA)
Substance Abuse Intensive Outpatient Program
Substance Abuse Comprehensive Outpatient Treatment
Substance Abuse Non-Medical Community Residential Treatment
Substance Abuse Medically Monitored Residential Treatment
Ambulatory Detoxification
Non-Hospital Medical Detoxification
Medically Supervised Detoxification/Crisis Stabilization
Evaluation/Assessments/Individual Outpatient Psychotherapy/Outpatient Family Therapy/Group Therapy
Professional Treatment Services in Facility-Based Crisis Programs
Opioid Treatment

Table of Contents

Introduction

As part of Mental Health Reform, this bulletin will address the remaining Enhanced Benefit Mental Health/Substance Abuse Services. The State Plan Amendment has been approved and will be implemented in March 2006. [**Note:** Targeted Case Management for persons with developmental disabilities is in a separate State Plan Amendment which has not yet been approved.] Enrollment for each service will not begin until the endorsement window for that service has been opened. The schedule for endorsement windows can be found at **http://www.dhhs.state.nc.us/mhddsas/announce/index.htm** under Communication Bulletin # 47. Please refer to the DMA website **http://www.dhhs.state.nc.us/dma** for the complete definition with all of the specific requirements, limitations, and provider qualifications of each definition.

Provider Information

All prospective providers must obtain endorsement from the local management entity (LME) for each service they wish to provide before requesting to become a Medicaid approved Community Intervention Service (CIS) provider. Current CIS providers must also receive an endorsement to provide additional service components under Community Intervention Services program.

Once the endorsement has been received, prospective providers must submit a completed CIS Application Packet to the Division of Medical Assistance at the address listed below. Current CIS providers must submit a completed CIS Addendum Enrollment Application indicating each component for which they have received an endorsement and seek enrollment with Medicaid to provide. The application and instructions for completing the application are located on the Divisions of Medical Assistance (DMA) website at http://www.dhhs.state.nc.us/dma/provenroll.htm.

Completed application packets must be mailed to:

DMA Provider Services
Attn: CIS Enrollment Specialist
2501 Mail Service Center
Raleigh, NC 27699-2501

Note: If you wish to be notified of the date your packet is received at DMA, you must complete and attach postage to the application acknowledgement card.

Please continue to visit our website at http://www.dhhs.state.nc.us/dma/provenroll.htm for further information relating to CIS enrollment, and to the Division of Mental Health's website at http://www.dhhs.state.nc.us/mhddsas/announce/index.htm for information pertaining to endorsement. To contact your local management entity, please refer to the LME Directory online at http://www.dhhs.state.nc.us/mhddsas/lmedirectory.htm.

Approved providers are assigned a CIS agency core number and an attending number for each service component they have been approved and endorsed to provide. Providers will be notified by mail once the enrollment process has been completed. All claims must be submitted with the agency core number and the attending number for the specific service being provided.

The following table outlines the alpha suffix that will be assigned as providers are endorsed and enrolled for each of these particular services.

Billing Code	Alpha Character	Service Description
H2012 HA	R	Child and Adolescent Day Treatment
H0015	Q	Substance Abuse Intensive Outpatient Program
H2035	P	Substance Abuse Comprehensive Outpatient Treatment
H0012 HB	N	Substance Abuse Non-Medical Community Residential Treatment - Adult
H0013	O	Substance Abuse Medically Monitored Residential Treatment
H0014	L	Ambulatory Detoxification
H0010	M	Non-Hospital Medical Detoxification
H2036	U	Medically Supervised or ADATC Detoxification/Crisis Stabilization
S9485	C	Professional Treatment Services in Facility-Based Crisis Programs - Adults
H0020	T	Opioid Treatment

Providers may also refer to Basic Medicaid Guidelines currently listed on the DMA web site as Basic Medicaid Billing Guide 2005 **http://www.dhhs.state.nc.us/dma/medbillcaquide.htm** or the mental health clinical coverage policies currently listed on the DMA web site at **http://ww.dhhs.state.nc.us/dma/mp/mpindex.htm** for detailed information on recipient coverage limitations.

Eligible Recipients

Medicaid eligible recipients may have service restrictions due to their eligibility category that would make them ineligible for Mental Health services.

Special Provision

For recipients under the age of 21, additional products, services, or procedures may be requested even if they do not appear in the NC State Plan or when coverage is limited to those over 21 years of age. Service limitations on scope, amount, or frequency described in the coverage policy may not apply if the product, service, or procedure is medically necessary.

Recipients will receive notification of any denial, reduction, suspension or termination of a service and their appeal rights.

Service Definitions

1. Child and Adolescent Day Treatment – H2012 HA

This service is available for children from age 3 through age 20 and includes therapeutic or rehabilitation goals of the consumer in a structured setting. This is an existing service which has been modified to increase provider qualifications, require additional training for providers and require prior authorization. The interventions are outlined in the child/adolescent person centered treatment plan and include behavioral interventions, social and other skill development, enhancement of communication, problem-solving skills, anger management, monitoring of psychiatric symptoms, psycho-educational activities as appropriate. These interventions are designed to support symptom stability, increase the recipient's ability to cope and relate to others and enhancing the highest level of functioning possible. The service will also contain a case management component with assessment, monitoring, linking to services and coordination of care. This service must be available at least three hours a day and at a minimum of 2 days a week in a licensed program.

Provider and Staffing Requirements:

All services in the milieu are provided by a team which may have the following configuration; Providers meet the Qualified Professional (QP), Associate Professionals (AP) and paraprofessionals (according to the requirements of 10A NCAC 27G). Programs serving children with Substance Abuse (SA) must have a CCS, LCAS, or CSAC providing services.

Service Limitations:

This service will be billed in one (1) hour increments.

An order by an Physician (MD), PhD, Nurse Practitioner (NP) or Physician's Assistant (PA) for the service is required and prior authorization will be required by the Local Management Entities (LMEs) or the state Utilization Review (UR) vendor. This service can only be provided by one day treatment provider at a time and cannot be billed on the same day as any inpatient or any other intensive in home service.

This service should be billed with the alpha character R appended to the attending provider number.

2. Substance Abuse Intensive Outpatient Program – H0015

This service provides motivational enhancement and engagement strategies, random alcohol/drug testing and strategies for relapse prevention to include community and/or other strategies for relapse preventions.

Provider and Staffing Requirements:

This service can only be provided by qualified substance abuse professional staff with the following licenses or certifications: Licensed Psychological Associates (LPA), Licensed Professional Counselors (LPC), Licensed Clinical Social Workers (LCSW), Certified Substance Abuse Counselors CSAC), Licensed Clinical Addiction Specialists (LCAS), and Certified Clinical Supervisor (CCS). Qualified Professional (QP), Associate Professional (AP), or paraprofessional with Substance Abuse (SA) experience can provide service under supervision of CCS or LCAS. Program is under the clinical supervision of CCS or LCAS who is on-site a minimum of 50% of the hours of operation.

Service Limitations:

Prior authorization by the statewide vendor or approved LME contracted with Medicaid is required. The amount, duration, and frequency of services must be included in the individual PCP (Person Centered Plan) and authorized on or before the day services are to be provided. The initial authorization for services must not exceed 12 weeks. Under exceptional circumstances, one additional reauthorization for up to two (2) weeks can be approved.

The service must be available for a minimum of 3 hours per day, operated out of a licensed substance abuse facility and can be provided in a variety of settings. Service must be available a minimum of 3 days per week with a maximum of 19 hours per week. The maximum face to face ratio is an average of not more than 12 recipients to 1 direct service staff based on average daily attendance.
This service should be billed with the alpha character Q appended to the attending provider number.

3. Substance Abuse Comprehensive Outpatient Treatment – H2035

This is a periodic service that is a time-limited, multifaceted service approach for adults who require structure and support to achieve and sustain recovery. It emphasizes reduction in use and abuse of substances and/or continued abstinence, the negative consequences of substance abuse and development of support network necessary to support necessary life style changes and the continued commitment to recovery. The individual components of the services include individual and group counseling, family counseling and support, biochemical assays to identify drug use, strategies for relapse prevention, life skills, crisis contingency planning, disease management and treatment support for recipients with physical disabilities or co-occurring disorders. Recipients must have ready access to psychiatric assessment and treatment services when warranted by the presence of symptoms indicating a co-occurring disorder. Prior approval is required, medical necessity is imbedded in the definition.

Provider and Staffing Requirements:

Staff must meet the requirements for CCS, LCAS, and CSAC or a Qualified Professional or AP Associate Professional (according to the requirements of 10A NCAC 27G). Paraprofessionals can provide services if under the supervision of the LCAS or CCS but not in lieu of a Qualified Professional position.

Service Limitations:

This service must be ordered by an MD, PhD, NP or PA, must operate at least 20 hours per week and offer a minimum of 4 hours of scheduled services per day with availability of at least 5 days per week with no more than a 2 day lapse between services.

This service will be billed on a per hour basis. Prior approval is required by an approved LME contracted with Medicaid or the statewide vendor.

This service should be billed with the alpha character P appended to the attending provider number.

4. Substance Abuse Non-Medical Community Residential Treatment For Adults - H0012 HB

This service is not available in any facility that has more than 16 beds. It is a 24 hour professionally supervised residential recovery program that works intensively with substance abuse disorders of adults

who provide or have the potential to be the primary caregiver for their minor children. It is a rehabilitation facility without medical nursing/monitoring where a planned program of professionally directed evaluation, care, and treatment for the restoration of functioning for individuals with an addictions disorder. Programs include assessment/referral, individual and group therapy, family recovery, recovery skills training, case management, disease management, symptoms monitoring, medication monitoring and self management of symptoms. Education services will be arranged although they are not reimbursed as a part of this service. For programs serving individuals with their children, the person centered plan will include services such as training in therapeutic parenting skills, basic independent living skills, child supervision. In addition, their children shall receive services in accordance with 10A NCAC 27G.4100.

Provider and Staffing Requirements:

Staff requirements are CCS, LCAS and CSAC (according to the requirements of 10A NCAC 27G). Program is supervised by LCAS or CCS who is on-site a minimum of 8 hours per day and available by phone 24 hours per day. Qualified Professional, Associate Professional, and paraprofessionals can provide services under the supervision of LCAS or CCS.

Service Limitations:

This service cannot be billed on the same day as any other mental health or substance abuse service. Medicaid will not pay room and board and will pay only the treatment component. This service must have an order and will be subject to prior approval by an approved LME contracted with Medicaid or Medicaid state vendor.

This service will be billed on a per diem basis and cannot be billed for more than 30 days in a 12 month period.

This service should be billed with the alpha character N appended to the attending provider number.

5. Substance Abuse Medically Monitored Residential Treatment – H0013

This is a non hospital medically monitored facility with less than sixteen (16) beds that provides 24-hour medical/nursing monitoring. It also includes a planned program of professionally directed evaluation, care, and treatment for the restoration of functioning for adults with alcohol and other drug problems/addictions.

Provider and Staffing Requirements:

Staff requirements are CCS, LCAS, CSAC, Qualified Professional, Associate Professionals, and paraprofessionals (according to the requirements of 10A NCAC 27G) with training and expertise with this population. Program is under the supervision of LCAS or CCS who is on-site a minimum of 8 hours per day and available 24 hours per day by phone. RN must be available to conduct nursing assessment upon admission and oversee monitoring of progress and medication administration.

Service Limitations:

The service requires an order by an MD, PhD, NP or PA and prior approval is required by an approved LME or the statewide vendor. This service cannot be billed for more than 30 days in a 12 month period.

This service should be billed with the alpha character O appended to the attending provider number.

6. Ambulatory Detoxification – H0014

Ambulatory detox is an organized service delivered by trained practitioners who provide medically supervised evaluations, detoxification and referral services according to a predetermined schedule. A physician is available 24/7 to conduct an assessment within 24 hours of admission. A registered nurse is available to conduct a nursing assessment on admission and oversee the monitoring of patient's progress and medications.

Provider and Staffing Requirements:

These services are provided in regularly scheduled sessions by a CCS, LCAS, QP or AP (according to the requirements of 10A NCAC 27G.

Service Limitations:

The service requires an order by an MD, PhD, NP or PA and prior approval is required by an approved LME contracted with Medicaid or the statewide vendor.

This service will be billed in fifteen (15) minute increments.

This service should be billed with the alpha character L appended to the attending provider number.

7. Non-Hospital Medical Detoxification – H0010

Medically monitored detoxification is an organized service by medical and nursing professionals that provides for 24 hour medically supervised evaluations and withdrawal management in a permanent facility affiliated with a hospital or in a freestanding facility of 16 beds or less. The specifics of admission criteria are included in the definition; the service is provided to adults.

Provider and Staffing Requirements:

It is staffed by CCS, LCAS, CSAC, QP, AP and paraprofessionals (according to the requirements of 10A NCAC 27G. A physician is available 24 hours a day by telephone and conducts an assessment within 24 hours of admission. A registered nurse is available to conduct a nursing assessment on admission and oversee the monitoring of patient's progress and medications.

Service Limitations:

The service requires an order by an MD, PhD, NP or PA and prior approval is required by an approved LME contracted with Medicaid or the statewide vendor.

This service will be billed on a per diem basis and cannot be billed for more than 30 days in a 12 month period.

This service should be billed with the alpha character M appended to the attending provider number.

8. Medically Supervised Detoxification/Crisis Stabilization – H2036

This is an organized service delivered by medical and nursing personnel that provides 24 hour medically supervised evaluation and withdrawal management to adults in a permanent facility with 16 or less beds. Services are delivered under a defined set of physician approved policies and physician monitored procedures and clinical protocols. Recipients are often in crisis due to co-occurring severe substance related mental disorders and are in need of short term intensive evaluation, treatment intervention or behavioral management to stabilize the acute or crisis situation. Recipients are carefully evaluated to ensure they obtain the appropriate level of care.

Provider and Staffing Requirements:

A registered nurse is available to conduct a nursing assessment on admission and oversee the monitoring of patient's progress and medications on an hourly basis. Appropriately licensed and credentialed staff is available to administer medications in accordance with physician's orders.

Service Limitations:

The service requires an order by an MD, PhD, NP or PA and prior approval is required by an approved LME contracted with Medicaid or the statewide vendor. This service cannot be billed for more than 30 days in a 12 month period

This service should be billed with the alpha character U appended to the attending provider number.

9. Evaluation/Assessments/Individual Outpatient Psycho-therapy/Outpatient Family Therapy/ Group Therapy

The January 2005 and May 2005 Medicaid Special Bulletins contain information about this service, the provider types, and billing information. These bulletins are posted on the DMA website http://www.dhhs.state.nc.us/dma.

10. Professional Treatment Services in Facility-Based Crisis Programs For Adults -

This existing service serves as an alternative to hospitalization for adults who have mental illness/developmental disability/substance abuse disorder. It is a 24 hour residential facility that provides support and crisis services in a community setting. The services are provided under the supervision of a physician with interventions implemented under the physician direction. The purpose is to implement intensive treatment, behavioral management, interventions or detoxification protocols, to stabilize the immediate problems and to ensure the safety of the individual. It is offered 7 days /week and must be provided in a licensed facility.

Provider and Staffing Requirements:

At no time will the staff to recipient ratio be less the 1:6 for adult mental health recipients, 1:9 for substance abuse recipients.

Service Limitation:

This is a short term service that does not exceed 15 days. This service cannot be billed for more than a total of 30 days in a 12 month period

Prior approval will be required by the Medicaid statewide vendor or the approved LME contracted with Medicaid at the end of 7 days if additional days are needed.

This service will be billed on an hourly basis.

This service should be billed with the alpha character C appended to the attending provider number.

11. Opioid Treatment – H0020

The program must be licensed and must meet the state and federal guidelines for this program before beginning the endorsement process. This medical service is provided through the LMEs for the treatment of Opioid addiction. The service must be provided in conjunction with rehabilitation and medical services. It is provided for detoxification treatment and maintenance.

Provider and Staffing Requirements*:*

The program must be licensed and must meet the Federal Guidelines for this program. It is provided by an RN, LPN, Pharmacist or MD.

Service Limitation:

This service will require prior approval by the approved LME contracted with Medicaid or the Medicaid statewide vendor.

This service will be billed per event.

This service should be billed with the alpha character T appended to the attending provider number.

Instructions for Completing a Claim for Enhanced Benefit Mental Health/Substance Abuse Services

Refer to the following information for completing a CMS-1500 claim form for the above services.

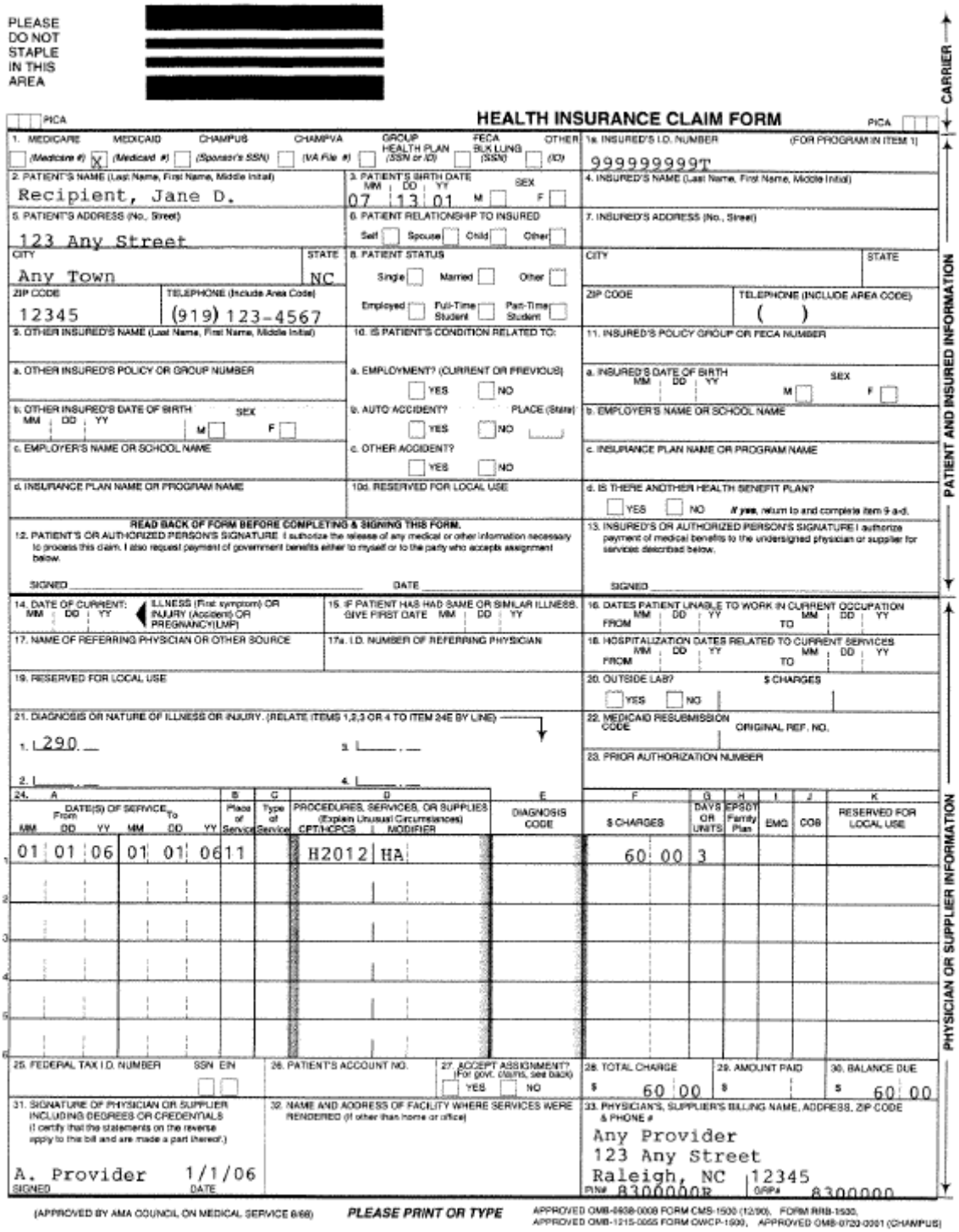
Block #/Description	Instruction
1.	Place an **X** in the MEDICAID block.
1a. Insured's ID Number	Enter the recipient's Medicaid ID number (nine digits and the alpha suffix) exactly as it is shown on the recipient's Medicaid ID card.
2. Recipient's Name	Enter the recipient's last name, first name and middle initial exactly as it is shown on the Medicaid ID card.
3. Recipient's Birth Date/Sex	Enter eight numbers to show the recipient's date of birth - MMDDYYYY. The birth date is on the Medicaid ID card. ***EXAMPLE:*** *November 14, 1949 is* **11141949***.* Place an **X** in the appropriate block to show the recipient's sex.
4. Insured's Name.	Leave blank
5. Recipient's Address	Enter the recipient's street address, including the city, state and zip code. The information is on the Medicaid ID card. Entering the telephone number is optional.
6. – 8.	Leave blank.
9. Other Insurer's Name	Enter applicable private insurer's name.
9a. – 9d.	Enter applicable insurance information.
10. Is Recipient's Condition…?	Place an **X** in the appropriate block for each question.
11. – 14.	Optional.
15. – 16.	Leave blank.
17., 17a., and 18.	Optional.
19. Reserved for Local Use	Leave blank.
20. Outside Lab…	Leave blank.
21. Diagnosis or Nature of Illness	Enter the ICD-9-CM code(s) to describe the primary diagnosis related to the service. You may also enter related secondary diagnoses. Entering written descriptions is optional.
22. Medicaid Resubmission Code	Leave blank.
23. Prior Authorization Number	Leave blank.

Note: Blocks 24A through 24K are where you provide the details about what you are billing. There are several lines for listing services. Each line is called a "detail." When completing these blocks:

- Use one line for each HCPCS code that you bill on a given date.
- If you provide more than one unit of the same item on one day, include all the items on the same line.
- Include only dates of service for which the recipient is eligible for Medicaid.

Block #/Description	Instruction
24a. Date(s) of Service, From/To	Enter the date of service in the “From” date field and then the same date in the “To” date field.
24b. Place of Service	Enter the appropriate place of service code.
24c. Type of Services	Leave blank.
24d. Procedures, Services…	Enter the appropriate HCPC code and modifier (if applicable) for the service being provided.
24e. Diagnosis Code	Leave blank.
24f. Charges	Enter the total charge for the items on the line.
24g. Days or Units	Enter the number of units. (i.e. 1unit = 15 minutes or 1 unit = 1 day)
24h. – 24i.	Leave blank.
24j. – 24k.	Optional.
25. Federal Tax ID Number	Optional
26. Recipient’s Account No.	Optional. You may enter your agency’s record or account number for the recipient. The entry may be any combination of numbers and letters up to a total of nine characters. If you enter a number, it will appear on your RA. This will assist in reconciling your accounts.
27. Accept Assignment	Leave blank.
28. Total Charge	Enter the sum of the charges listed in Item **24F**.
29. Amount Paid	Enter the total amount received from third party payment sources if service is subject to Third Party.
30. Balance Due	Subtract the amount in Item **29** from the amount in Item **28** and enter the result here.
31. Signature of Physician or Supplier…	Leave blank if there is a signature on file with Medicaid. Otherwise, an authorized representative of your agency must sign and date the claim in this block. A written signature stamp is acceptable.
32. Name and Address of Facility...	Optional.
33. Physician's/ Supplier's Billing Name...	Enter your agency's name, address, including ZIP code, and phone number. The name and address must be EXACTLY as shown on your Medicaid participation agreement.
PIN#	Enter your seven-digit Medicaid attending provider number with the appropriate alpha character which defines the service being provided.
GRP#	Enter your seven-digit Medicaid billing provider number.

Claim Form Examples



PLEASE DO NOT STAPLE IN THIS AREA

[redacted]

PICA

HEALTH INSURANCE CLAIM FORM

PICA

CARRIER

1. MEDICARE (Medicare #) | MEDICAID (Medicaid #) X | CHAMPUS (Sponsor's SSN) | CHAMPVA (VA File #) | GROUP HEALTH PLAN (SSN or ID) | FECA BLK LUNG (SSN) | OTHER (ID)

1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1): 999999999T

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): Recipient, Jane D.

3. PATIENT'S BIRTH DATE MM DD YY: 07 13 01 SEX M F

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No., Street): 123 Any Street

6. PATIENT RELATIONSHIP TO INSURED: Self | Spouse | Child | Other

7. INSURED'S ADDRESS (No., Street)

CITY: Any Town STATE: NC

8. PATIENT STATUS: Single | Married | Other; Employed | Full-Time Student | Part-Time Student

CITY STATE

ZIP CODE: 12345 TELEPHONE (Include Area Code): (919) 123-4567

ZIP CODE TELEPHONE (INCLUDE AREA CODE) ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (CURRENT OR PREVIOUS) YES NO

a. INSURED'S DATE OF BIRTH MM DD YY SEX M F

b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX M F

b. AUTO ACCIDENT? YES NO PLACE (State)

b. EMPLOYER'S NAME OR SCHOOL NAME

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? YES NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES NO If yes, return to and complete item 9 a-d.

PATIENT AND INSURED INFORMATION

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED _____ DATE _____

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED _____

14. DATE OF CURRENT: MM DD YY ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO

17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE

17a. I.D. NUMBER OF REFERRING PHYSICIAN

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? YES NO $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE)

1. L290.__ 3. L___.__

2. L___.__ 4. L___.__

22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B Place of Service	C Type of Service	D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E DIAGNOSIS CODE	F $ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	I EMG	J COB	K RESERVED FOR LOCAL USE
01 01 06	01 01 06	11		H2012	HA		60 00	3				

PHYSICIAN OR SUPPLIER INFORMATION

25. FEDERAL TAX I.D. NUMBER SSN EIN

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES NO

28. TOTAL CHARGE $ 60 00

29. AMOUNT PAID $

30. BALANCE DUE $ 60 00

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

A. Provider 1/1/06

SIGNED DATE

32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (if other than home or office)

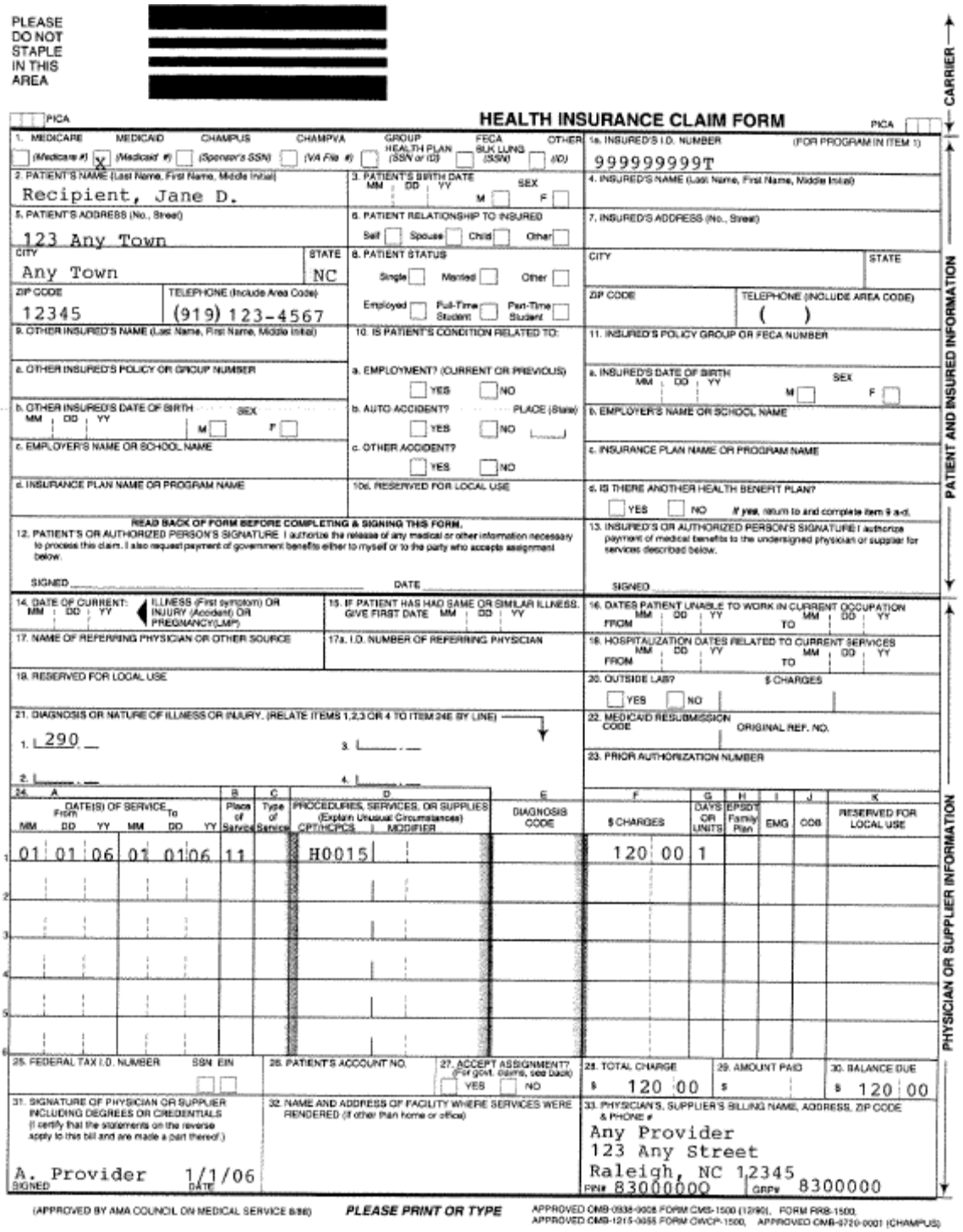
33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #

Any Provider
123 Any Street
Raleigh, NC 12345

PIN# 8300000R GRP# 8300000

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8/88) **PLEASE PRINT OR TYPE**

APPROVED OMB-0938-0008 FORM CMS-1500 (12/90), FORM RRB-1500, APPROVED OMB-1215-0055 FORM OWCP-1500, APPROVED OMB-0720-0001 (CHAMPUS)



PLEASE DO NOT STAPLE IN THIS AREA

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PICA

HEALTH INSURANCE CLAIM FORM

PICA

CARRIER

1. MEDICARE (Medicare #) | MEDICAID (Medicaid #) X | CHAMPUS (Sponsor's SSN) | CHAMPVA (VA File #) | GROUP HEALTH PLAN (SSN or ID) | FECA BLK LUNG (SSN) | OTHER (ID)

1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1): 999999999T

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): Recipient, Jane D.

3. PATIENT'S BIRTH DATE MM DD YY; SEX M F

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No., Street): 123 Any Town

6. PATIENT RELATIONSHIP TO INSURED: Self | Spouse | Child | Other

7. INSURED'S ADDRESS (No., Street)

CITY: Any Town | STATE: NC

8. PATIENT STATUS: Single | Married | Other; Employed | Full-Time Student | Part-Time Student

CITY | STATE

ZIP CODE: 12345 | TELEPHONE (Include Area Code): (919) 123-4567

ZIP CODE | TELEPHONE (INCLUDE AREA CODE): ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (CURRENT OR PREVIOUS) YES NO

a. INSURED'S DATE OF BIRTH MM DD YY; SEX M F

b. OTHER INSURED'S DATE OF BIRTH MM DD YY; SEX M F

b. AUTO ACCIDENT? YES NO PLACE (State)

b. EMPLOYER'S NAME OR SCHOOL NAME

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? YES NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES NO If yes, return to and complete item 9 a-d.

PATIENT AND INSURED INFORMATION

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE. I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED _____ DATE _____

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED

14. DATE OF CURRENT: MM DD YY; ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM; MM DD YY TO

17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE

17a. I.D. NUMBER OF REFERRING PHYSICIAN

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM; MM DD YY TO

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? YES NO; $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE)

1. L 290 .

2. L . 3. L . 4. L .

22. MEDICAID RESUBMISSION CODE | ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B Place of Service	C Type of Service	D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E DIAGNOSIS CODE	F $ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	I EMG	J COB	K RESERVED FOR LOCAL USE
1 01 01 06	01 01 06	11		H0015			120 00	1				
2												
3												
4												
5												
6												

PHYSICIAN OR SUPPLIER INFORMATION

25. FEDERAL TAX I.D. NUMBER SSN EIN

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES NO

28. TOTAL CHARGE $ 120 00

29. AMOUNT PAID $

30. BALANCE DUE $ 120 00

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

A. Provider SIGNED 1/1/06 DATE

32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)

33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #

Any Provider
123 Any Street
Raleigh, NC 12345
PIN# 8300000Q GRP# 8300000

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8/88) **PLEASE PRINT OR TYPE**

APPROVED OMB-0938-0008 FORM CMS-1500 (12/90), FORM RRB-1500,
APPROVED OMB-1215-0055 FORM OWCP-1500, APPROVED OMB-0720-0001 (CHAMPUS)

PLEASE DO NOT STAPLE IN THIS AREA

[redacted]

CARRIER

PICA

HEALTH INSURANCE CLAIM FORM

PICA

PATIENT AND INSURED INFORMATION

1. MEDICARE / MEDICAID / CHAMPUS / CHAMPVA / GROUP HEALTH PLAN (SSN or ID) / FECA BLK LUNG (SSN) / OTHER (ID) — (Medicaid #) X 999999999T — (FOR PROGRAM IN ITEM 1)

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)	3. PATIENT'S BIRTH DATE / SEX	4. INSURED'S NAME (Last Name, First Name, Middle Initial)
Recipient, Jane D	M F	
5. PATIENT'S ADDRESS (No., Street)	6. PATIENT RELATIONSHIP TO INSURED	7. INSURED'S ADDRESS (No., Street)
123 Any Town	Self Spouse Child Other	
CITY: Any Town — STATE: NC	8. PATIENT STATUS: Single Married Other	CITY — STATE
ZIP CODE: 12345 — TELEPHONE (Include Area Code): (919) 123-4567	Employed Full-Time Student Part-Time Student	ZIP CODE — TELEPHONE (INCLUDE AREA CODE) ( )
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)	10. IS PATIENT'S CONDITION RELATED TO:	11. INSURED'S POLICY GROUP OR FECA NUMBER
a. OTHER INSURED'S POLICY OR GROUP NUMBER	a. EMPLOYMENT? (CURRENT OR PREVIOUS) YES NO	a. INSURED'S DATE OF BIRTH / SEX M F
b. OTHER INSURED'S DATE OF BIRTH / SEX M F	b. AUTO ACCIDENT? YES NO PLACE (State)	b. EMPLOYER'S NAME OR SCHOOL NAME
c. EMPLOYER'S NAME OR SCHOOL NAME	c. OTHER ACCIDENT? YES NO	c. INSURANCE PLAN NAME OR PROGRAM NAME
d. INSURANCE PLAN NAME OR PROGRAM NAME	10d. RESERVED FOR LOCAL USE	d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES NO If yes, return to and complete item 9 a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.
SIGNED _____ DATE _____

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.
SIGNED _____

PHYSICIAN OR SUPPLIER INFORMATION

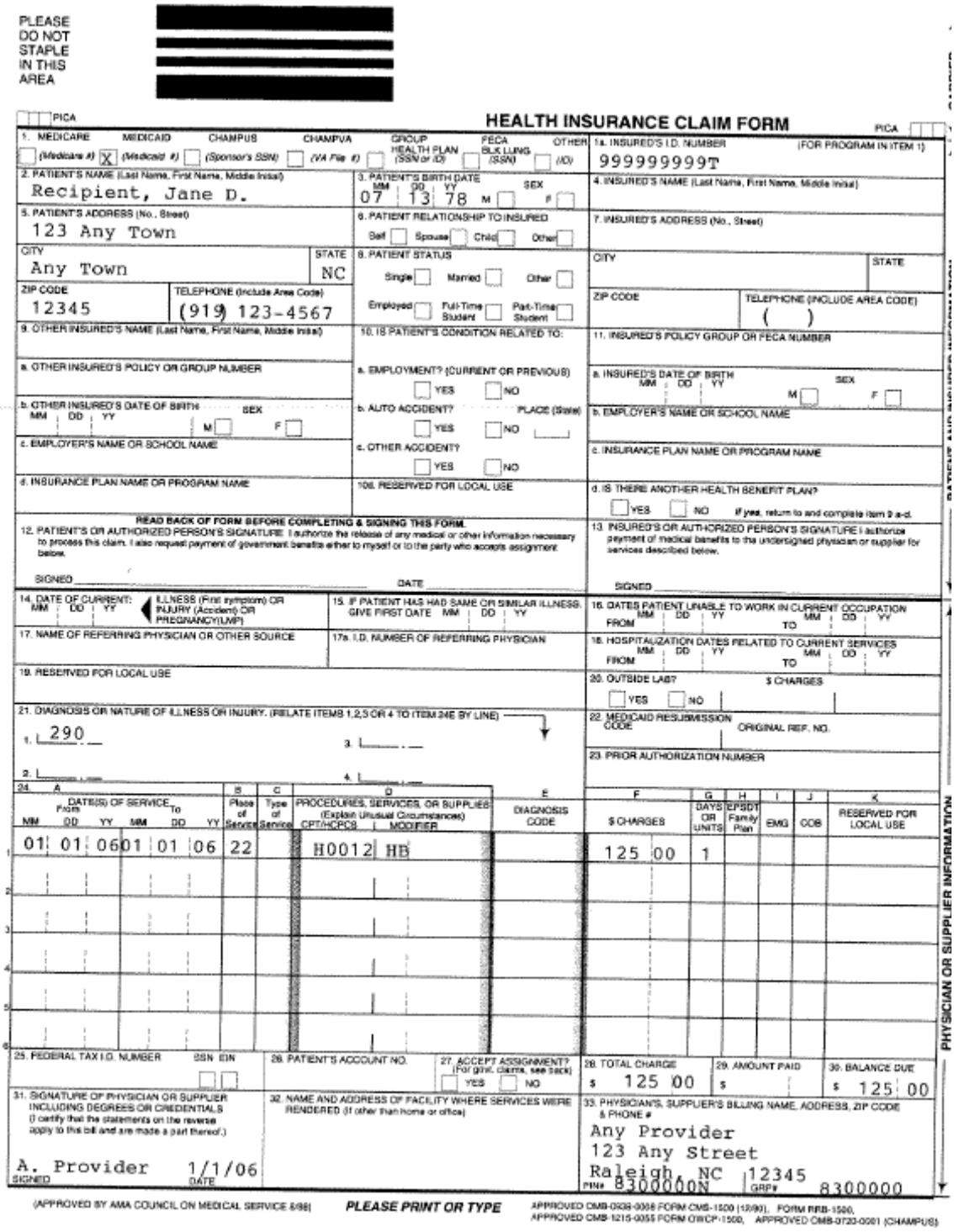
14. DATE OF CURRENT: ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)	15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE	16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION
		FROM TO
17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE	17a. I.D. NUMBER OF REFERRING PHYSICIAN	18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM TO
19. RESERVED FOR LOCAL USE		20. OUTSIDE LAB? YES NO — $ CHARGES
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE) 1. 290 2. 3. 4.		22. MEDICAID RESUBMISSION CODE — ORIGINAL REF. NO.
		23. PRIOR AUTHORIZATION NUMBER

24. A DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B Place of Service	C Type of Service	D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E DIAGNOSIS CODE	F $ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	I EMG	J COB	K RESERVED FOR LOCAL USE
1 01 01 06	01 01 06	11		H2035			120 00	1				
2												
3												
4												
5												
6												

25. FEDERAL TAX I.D. NUMBER SSN EIN	26. PATIENT'S ACCOUNT NO.	27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES NO	28. TOTAL CHARGE	29. AMOUNT PAID	30. BALANCE DUE
			$ 120 00	$	$ 120 00

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)	32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)	33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #
A. Provider 1/1/06 SIGNED DATE		Any Provider 123 Any Street Raleigh, NC 12345 PIN# 8300000P GRP# 8300000

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8/88) **PLEASE PRINT OR TYPE** APPROVED OMB-0938-0008 FORM CMS-1500 (12/90), FORM RRB-1500, APPROVED OMB-1215-0055 FORM OWCP-1500, APPROVED OMB-0720-0001 (CHAMPUS)



PLEASE DO NOT STAPLE IN THIS AREA

[redacted]

PICA

HEALTH INSURANCE CLAIM FORM

PICA

1. MEDICARE (Medicare #) MEDICAID [X] (Medicaid #) CHAMPUS (Sponsor's SSN) CHAMPVA (VA File #) GROUP HEALTH PLAN (SSN or ID) FECA BLK LUNG (SSN) OTHER (ID)		1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1): 999999999T
2. PATIENT'S NAME (Last Name, First Name, Middle Initial): Recipient, Jane D.	3. PATIENT'S BIRTH DATE MM DD YY: 07 13 78 SEX M F	4. INSURED'S NAME (Last Name, First Name, Middle Initial)
5. PATIENT'S ADDRESS (No., Street): 123 Any Town	6. PATIENT RELATIONSHIP TO INSURED: Self Spouse Child Other	7. INSURED'S ADDRESS (No., Street)
CITY: Any Town STATE: NC	8. PATIENT STATUS: Single Married Other; Employed Full-Time Student Part-Time Student	CITY STATE
ZIP CODE: 12345 TELEPHONE (Include Area Code): (919) 123-4567		ZIP CODE TELEPHONE (INCLUDE AREA CODE): ( )
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)	10. IS PATIENT'S CONDITION RELATED TO:	11. INSURED'S POLICY GROUP OR FECA NUMBER
a. OTHER INSURED'S POLICY OR GROUP NUMBER	a. EMPLOYMENT? (CURRENT OR PREVIOUS) YES NO	a. INSURED'S DATE OF BIRTH MM DD YY SEX M F
b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX M F	b. AUTO ACCIDENT? YES NO PLACE (State)	b. EMPLOYER'S NAME OR SCHOOL NAME
c. EMPLOYER'S NAME OR SCHOOL NAME	c. OTHER ACCIDENT? YES NO	c. INSURANCE PLAN NAME OR PROGRAM NAME
d. INSURANCE PLAN NAME OR PROGRAM NAME	10d. RESERVED FOR LOCAL USE	d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES NO If yes, return to and complete item 9 a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE: I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.
SIGNED _____ DATE _____

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE: I authorize payment of medical benefits to the undersigned physician or supplier for services described below.
SIGNED _____

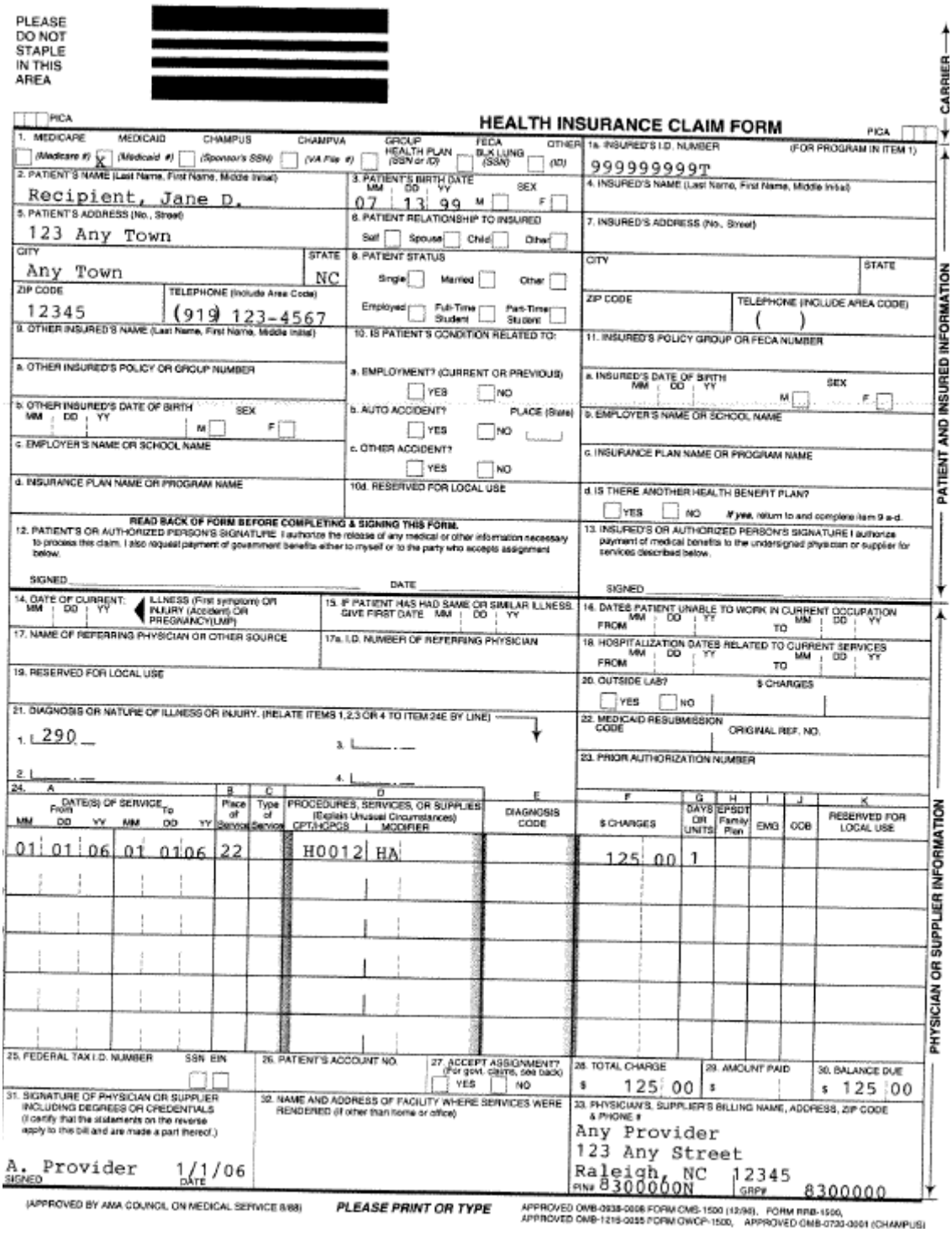
14. DATE OF CURRENT: MM DD YY ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)	15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE MM DD YY
16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO	
17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE	17a. I.D. NUMBER OF REFERRING PHYSICIAN
18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO	
19. RESERVED FOR LOCAL USE	20. OUTSIDE LAB? YES NO $ CHARGES
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE): 1. L 290 2. 3. 4.	22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.
	23. PRIOR AUTHORIZATION NUMBER

24. A DATE(S) OF SERVICE From MM DD YY To MM DD YY	B Place of Service	C Type of Service	D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER	E DIAGNOSIS CODE	F $ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	I EMG	J COB	K RESERVED FOR LOCAL USE
1 01 01 06 01 01 06	22		H0012 HB		125 00	1				
2										
3										
4										
5										
6										

25. FEDERAL TAX I.D. NUMBER SSN EIN	26. PATIENT'S ACCOUNT NO.	27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES NO	28. TOTAL CHARGE $ 125 00	29. AMOUNT PAID $	30. BALANCE DUE $ 125 00
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.) A. Provider SIGNED 1/1/06 DATE	32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)		33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE # Any Provider 123 Any Street Raleigh, NC 12345 PIN# 8300000N GRP# 8300000		

PHYSICIAN OR SUPPLIER INFORMATION

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8/88) ***PLEASE PRINT OR TYPE*** APPROVED OMB-0938-0008 FORM CMS-1500 (12/90), FORM RRB-1500, APPROVED OMB-1215-0055 FORM OWCP-1500, APPROVED OMB-0720-0001 (CHAMPUS)



PLEASE DO NOT STAPLE IN THIS AREA

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PICA

HEALTH INSURANCE CLAIM FORM

PICA

1. MEDICARE (Medicare #) [X] MEDICAID (Medicaid #) [ ] CHAMPUS (Sponsor's SSN) [ ] CHAMPVA (VA File #) [ ] GROUP HEALTH PLAN (SSN or ID) [ ] FECA BLK LUNG (SSN) [ ] OTHER (ID) [ ]

1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1): 999999999T

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): Recipient, Jane D.

3. PATIENT'S BIRTH DATE MM DD YY: 07 13 99 SEX M [ ] F [ ]

4. INSURED'S NAME (Last Name, First Name, Middle Initial):

5. PATIENT'S ADDRESS (No., Street): 123 Any Town

6. PATIENT RELATIONSHIP TO INSURED: Self [ ] Spouse [ ] Child [ ] Other [ ]

7. INSURED'S ADDRESS (No., Street):

CITY: Any Town STATE: NC

8. PATIENT STATUS: Single [ ] Married [ ] Other [ ] Employed [ ] Full-Time Student [ ] Part-Time Student [ ]

CITY: STATE:

ZIP CODE: 12345 TELEPHONE (Include Area Code): (919) 123-4567

ZIP CODE: TELEPHONE (INCLUDE AREA CODE): ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial):

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER:

a. OTHER INSURED'S POLICY OR GROUP NUMBER:

a. EMPLOYMENT? (CURRENT OR PREVIOUS) YES [ ] NO [ ]

a. INSURED'S DATE OF BIRTH MM DD YY: SEX M [ ] F [ ]

b. OTHER INSURED'S DATE OF BIRTH MM DD YY: SEX M [ ] F [ ]

b. AUTO ACCIDENT? YES [ ] NO [ ] PLACE (State):

b. EMPLOYER'S NAME OR SCHOOL NAME:

c. EMPLOYER'S NAME OR SCHOOL NAME:

c. OTHER ACCIDENT? YES [ ] NO [ ]

c. INSURANCE PLAN NAME OR PROGRAM NAME:

d. INSURANCE PLAN NAME OR PROGRAM NAME:

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES [ ] NO [ ] If yes, return to and complete item 9 a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE. I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED _____ DATE _____

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED _____

14. DATE OF CURRENT: MM DD YY ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP)

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO

17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE

17a. I.D. NUMBER OF REFERRING PHYSICIAN

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? YES [ ] NO [ ] $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE)

1. L 290 3. L

2. L 4. L

22. MEDICAID RESUBMISSION CODE: ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B Place of Service	C Type of Service	D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E DIAGNOSIS CODE	F $ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	I EMG	J COB	K RESERVED FOR LOCAL USE
01 01 06	01 01 06	22		H0012	HA		125 00	1				

25. FEDERAL TAX I.D. NUMBER SSN [ ] EIN [ ]

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES [ ] NO [ ]

28. TOTAL CHARGE $ 125 00

29. AMOUNT PAID $

30. BALANCE DUE $ 125 00

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

A. Provider 1/1/06
SIGNED DATE

32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)

33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #

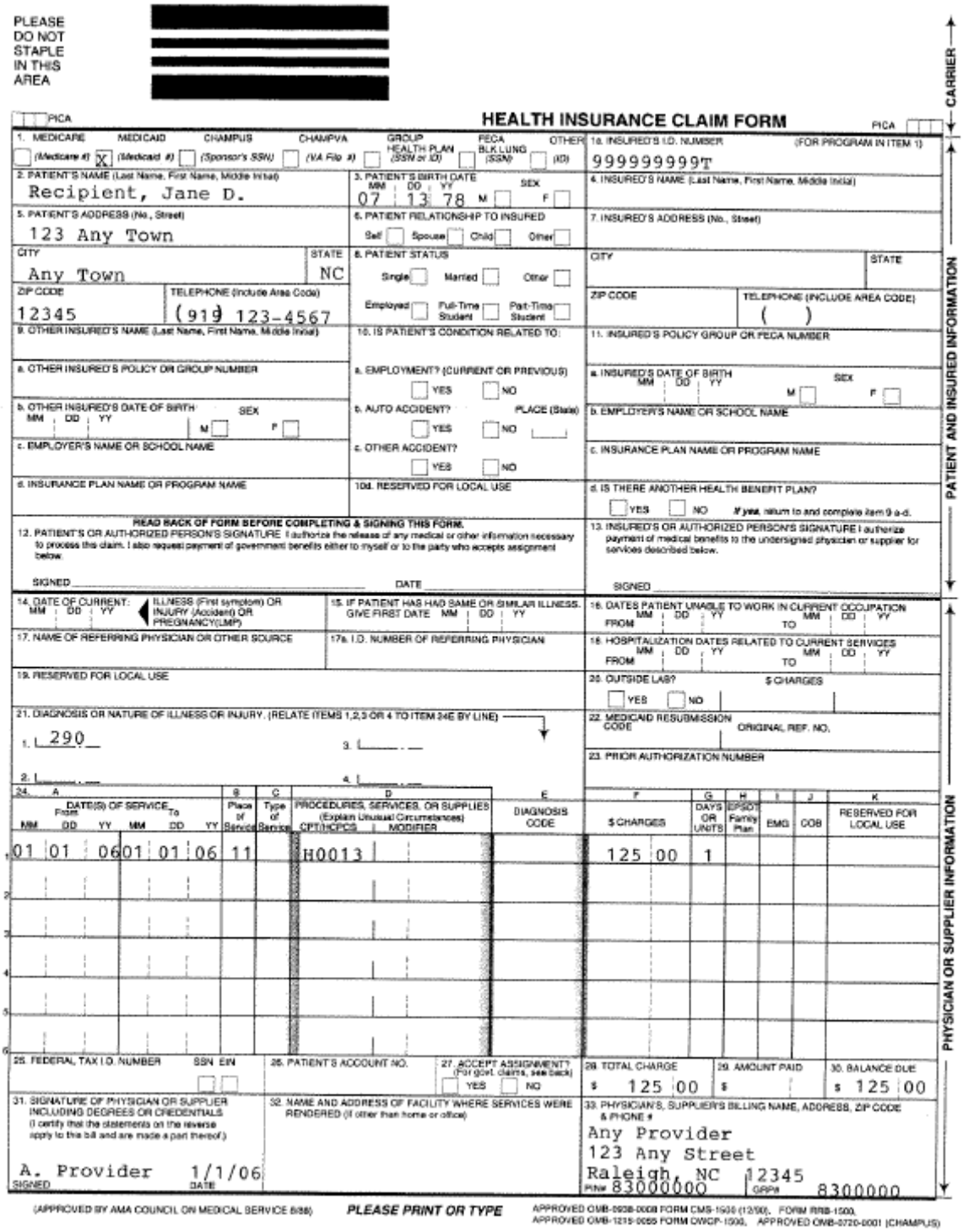
Any Provider
123 Any Street
Raleigh, NC 12345
PIN# 8300000N GRP# 8300000

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8/88) **PLEASE PRINT OR TYPE** APPROVED OMB-0938-0008 FORM CMS-1500 (12/90), FORM RRB-1500, APPROVED OMB-1215-0055 FORM OWCP-1500, APPROVED OMB-0730-0001 (CHAMPUS)



PLEASE DO NOT STAPLE IN THIS AREA

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PICA

HEALTH INSURANCE CLAIM FORM

PICA

CARRIER

1. MEDICARE (Medicare #) | MEDICAID (Medicaid #) X | CHAMPUS (Sponsor's SSN) | CHAMPVA (VA File #) | GROUP HEALTH PLAN (SSN or ID) | FECA BLK LUNG (SSN) | OTHER (ID)

1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1): 999999999T

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): Recipient, Jane D.

3. PATIENT'S BIRTH DATE MM DD YY: 07 13 78 | SEX: M | F

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No., Street): 123 Any Town

6. PATIENT RELATIONSHIP TO INSURED: Self | Spouse | Child | Other

7. INSURED'S ADDRESS (No., Street)

CITY: Any Town | STATE: NC

8. PATIENT STATUS: Single | Married | Other; Employed | Full-Time Student | Part-Time Student

CITY | STATE

ZIP CODE: 12345 | TELEPHONE (Include Area Code): (919) 123-4567

ZIP CODE | TELEPHONE (INCLUDE AREA CODE): ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (CURRENT OR PREVIOUS) YES | NO

a. INSURED'S DATE OF BIRTH MM DD YY | SEX: M | F

b. OTHER INSURED'S DATE OF BIRTH MM DD YY | SEX: M | F

b. AUTO ACCIDENT? YES | NO | PLACE (State)

b. EMPLOYER'S NAME OR SCHOOL NAME

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? YES | NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES | NO If yes, return to and complete item 9 a-d.

PATIENT AND INSURED INFORMATION

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED _____ DATE _____

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED _____

14. DATE OF CURRENT: MM DD YY | ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO MM DD YY

17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE

17a. I.D. NUMBER OF REFERRING PHYSICIAN

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO MM DD YY

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? YES | NO | $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE)

1. 290

2. _____

3. _____

4. _____

22. MEDICAID RESUBMISSION CODE | ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B Place of Service	C Type of Service	D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E DIAGNOSIS CODE	F $ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	I EMG	J COB	K RESERVED FOR LOCAL USE
1	01 01 06 01 01 06	11		H0013			125 00	1				
2												
3												
4												
5												
6												

PHYSICIAN OR SUPPLIER INFORMATION

25. FEDERAL TAX I.D. NUMBER: SSN | EIN

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES | NO

28. TOTAL CHARGE: $ 125 00

29. AMOUNT PAID: $

30. BALANCE DUE: $ 125 00

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

A. Provider 1/1/06

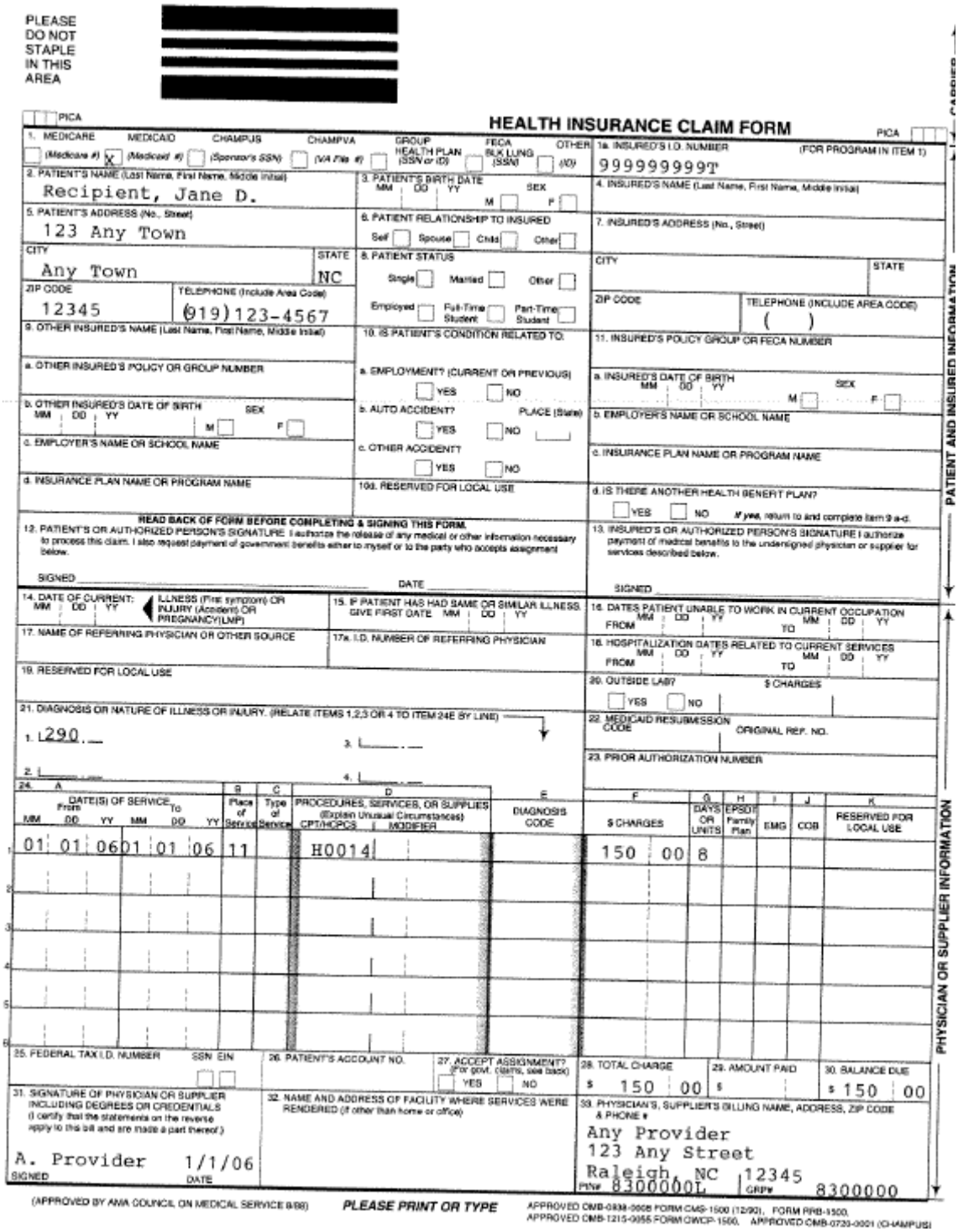
SIGNED DATE

32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)

33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #

Any Provider
123 Any Street
Raleigh, NC 12345
PIN# 83000000 GRP# 8300000

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8/88) **PLEASE PRINT OR TYPE** APPROVED OMB-0938-0008 FORM CMS-1500 (12/90). FORM RRB-1500, APPROVED OMB-1215-0055 FORM OWCP-1500, APPROVED OMB-0720-0001 (CHAMPUS)



PLEASE DO NOT STAPLE IN THIS AREA

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PICA

HEALTH INSURANCE CLAIM FORM

PICA

1. MEDICARE (Medicare #) | MEDICAID (X) (Medicaid #) | CHAMPUS (Sponsor's SSN) | CHAMPVA (VA File #) | GROUP HEALTH PLAN (SSN or ID) | FECA BLK LUNG (SSN) | OTHER (ID)

1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1): 999999999T

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): Recipient, Jane D.

3. PATIENT'S BIRTH DATE MM DD YY | SEX M ( ) F ( )

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No., Street): 123 Any Town

6. PATIENT RELATIONSHIP TO INSURED: Self ( ) Spouse ( ) Child ( ) Other ( )

7. INSURED'S ADDRESS (No., Street)

CITY: Any Town | STATE: NC

8. PATIENT STATUS: Single ( ) Married ( ) Other ( ) | Employed ( ) Full-Time Student ( ) Part-Time Student ( )

CITY | STATE

ZIP CODE: 12345 | TELEPHONE (Include Area Code): (919) 123-4567

ZIP CODE | TELEPHONE (INCLUDE AREA CODE): ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (CURRENT OR PREVIOUS) YES ( ) NO ( )

a. INSURED'S DATE OF BIRTH MM DD YY | SEX M ( ) F ( )

b. OTHER INSURED'S DATE OF BIRTH MM DD YY | SEX M ( ) F ( )

b. AUTO ACCIDENT? YES ( ) NO ( ) PLACE (State)

b. EMPLOYER'S NAME OR SCHOOL NAME

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? YES ( ) NO ( )

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES ( ) NO ( ) If yes, return to and complete item 9 a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE. I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

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13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE. I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED _____

14. DATE OF CURRENT: MM DD YY | ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP)

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO MM DD YY

17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE

17a. I.D. NUMBER OF REFERRING PHYSICIAN

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO MM DD YY

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? YES ( ) NO ( ) $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE)

1. L290.__ 3. ____ 2. ____ 4. ____

22. MEDICAID RESUBMISSION CODE | ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B Place of Service	C Type of Service	D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E DIAGNOSIS CODE	F $ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	I EMG	J COB	K RESERVED FOR LOCAL USE
1	01 01 06 01 01 06	11		H0014			150 00	8				
2												
3												
4												
5												
6												

25. FEDERAL TAX I.D. NUMBER SSN ( ) EIN ( )

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES ( ) NO ( )

28. TOTAL CHARGE $ 150 00

29. AMOUNT PAID $

30. BALANCE DUE $ 150 00

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

A. Provider 1/1/06
SIGNED DATE

32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)

33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #

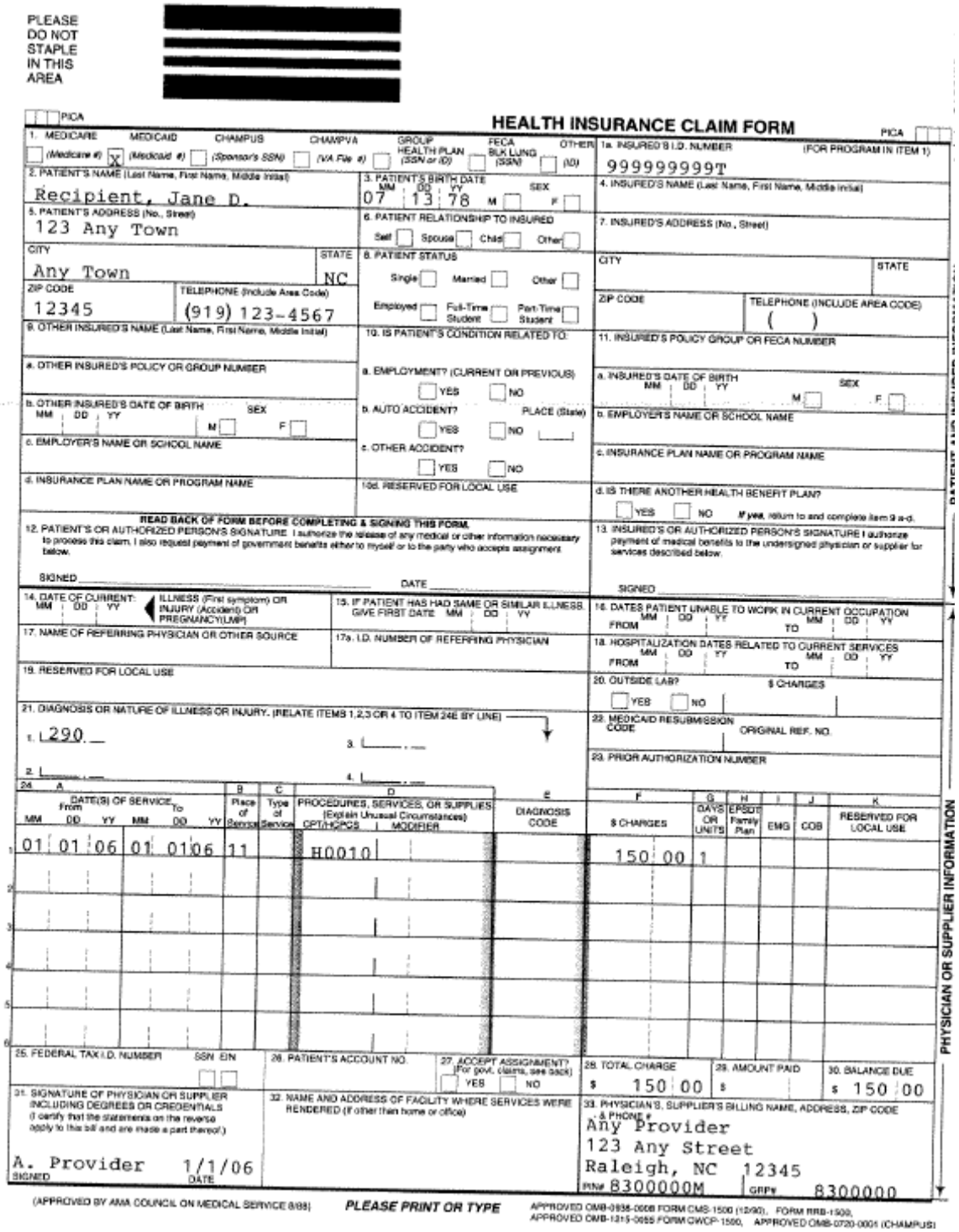
Any Provider
123 Any Street
Raleigh, NC 12345
PIN# 8300000L GRP# 8300000

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8/88) **PLEASE PRINT OR TYPE**

APPROVED OMB-0938-0008 FORM CMS-1500 (12/90), FORM RRB-1500,
APPROVED OMB-1215-0055 FORM OWCP-1500, APPROVED OMB-0720-0001 (CHAMPUS)



PLEASE DO NOT STAPLE IN THIS AREA

[redacted]

PICA

HEALTH INSURANCE CLAIM FORM

PICA

1. MEDICARE (Medicare #) | MEDICAID (Medicaid #) X | CHAMPUS (Sponsor's SSN) | CHAMPVA (VA File #) | GROUP HEALTH PLAN (SSN or ID) | FECA BLK LUNG (SSN) | OTHER (ID)

1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1): 999999999T

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): Recipient, Jane D.

3. PATIENT'S BIRTH DATE MM DD YY: 07 13 78 SEX M F

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No., Street): 123 Any Town

6. PATIENT RELATIONSHIP TO INSURED: Self | Spouse | Child | Other

7. INSURED'S ADDRESS (No., Street)

CITY: Any Town STATE: NC

8. PATIENT STATUS: Single | Married | Other; Employed | Full-Time Student | Part-Time Student

CITY STATE

ZIP CODE: 12345 TELEPHONE (Include Area Code): (919) 123-4567

ZIP CODE TELEPHONE (INCLUDE AREA CODE) ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (CURRENT OR PREVIOUS) YES NO

a. INSURED'S DATE OF BIRTH MM DD YY SEX M F

b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX M F

b. AUTO ACCIDENT? YES NO PLACE (State)

b. EMPLOYER'S NAME OR SCHOOL NAME

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? YES NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES NO If yes, return to and complete item 9 a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED _____ DATE _____

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED

14. DATE OF CURRENT: MM DD YY — ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO MM DD YY

17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE

17a. I.D. NUMBER OF REFERRING PHYSICIAN

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO MM DD YY

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? YES NO $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE)

1. L290.
2.
3.
4.

22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B Place of Service	C Type of Service	D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E DIAGNOSIS CODE	F $ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	I EMG	J COB	K RESERVED FOR LOCAL USE
1 01 01 06	01 01 06	11		H0010			150 00	1				
2												
3												
4												
5												
6												

25. FEDERAL TAX I.D. NUMBER SSN EIN

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES NO

28. TOTAL CHARGE $ 150 00

29. AMOUNT PAID $

30. BALANCE DUE $ 150 00

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

A. Provider 1/1/06
SIGNED DATE

32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)

33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #

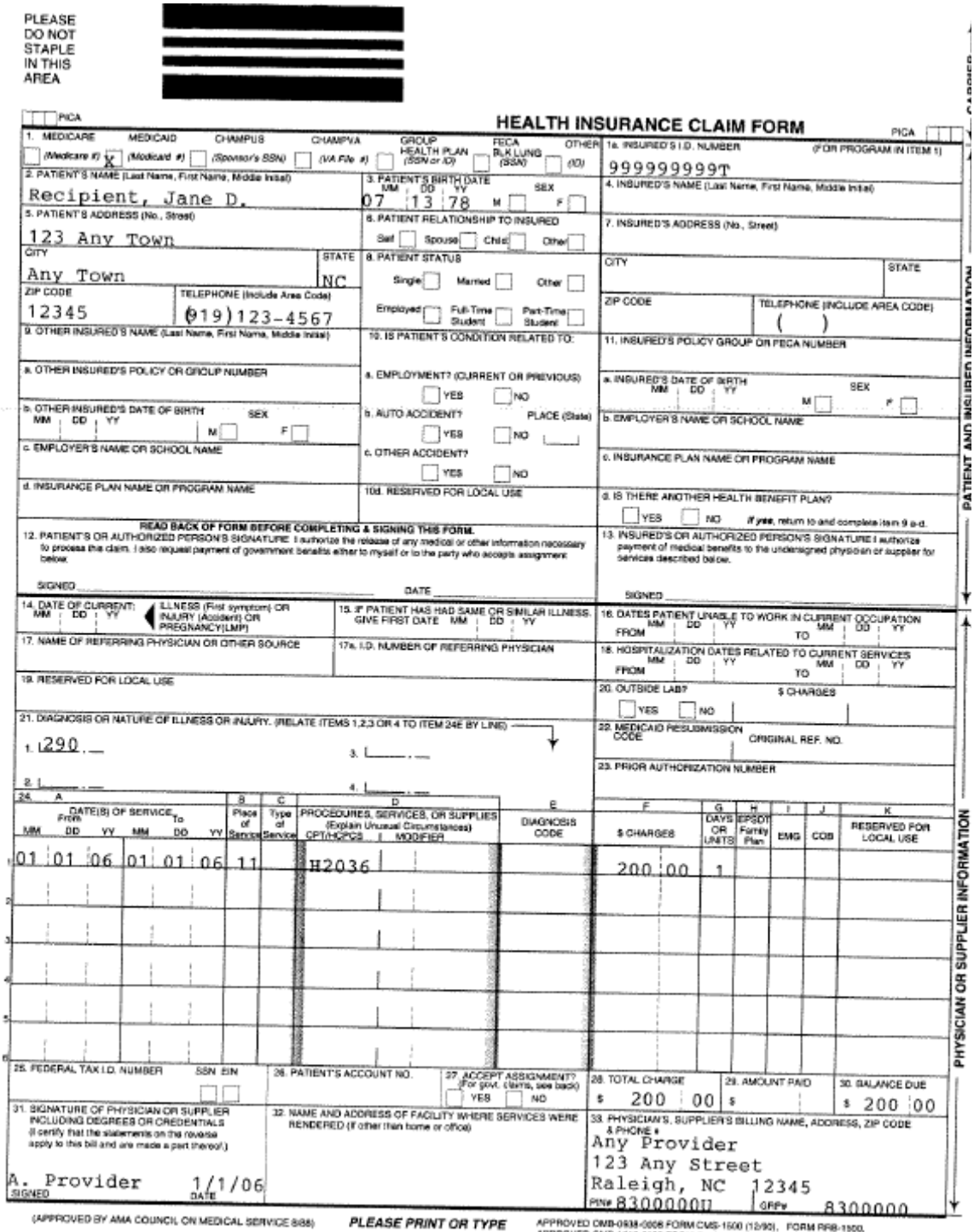
Any Provider
123 Any Street
Raleigh, NC 12345
PIN# 8300000M GRP# 8300000

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8/88) **PLEASE PRINT OR TYPE**

APPROVED OMB-0938-0008 FORM CMS-1500 (12/90), FORM RRB-1500, APPROVED OMB-1215-0055 FORM OWCP-1500, APPROVED OMB-0720-0001 (CHAMPUS)



PLEASE DO NOT STAPLE IN THIS AREA

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PICA

HEALTH INSURANCE CLAIM FORM

PICA

1. MEDICARE (Medicare #) X | MEDICAID (Medicaid #) | CHAMPUS (Sponsor's SSN) | CHAMPVA (VA File #) | GROUP HEALTH PLAN (SSN or ID) | FECA BLK LUNG (SSN) | OTHER (ID)

1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1): 999999999T

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): Recipient, Jane D.

3. PATIENT'S BIRTH DATE: 07 13 78 SEX: M ☐ F ☐

4. INSURED'S NAME (Last Name, First Name, Middle Initial):

5. PATIENT'S ADDRESS (No., Street): 123 Any Town

6. PATIENT RELATIONSHIP TO INSURED: Self ☐ Spouse ☐ Child ☐ Other ☐

7. INSURED'S ADDRESS (No., Street):

CITY: Any Town STATE: NC

8. PATIENT STATUS: Single ☐ Married ☐ Other ☐ Employed ☐ Full-Time Student ☐ Part-Time Student ☐

CITY: STATE:

ZIP CODE: 12345 TELEPHONE (Include Area Code): (919)123-4567

ZIP CODE: TELEPHONE (INCLUDE AREA CODE): ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial):

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (CURRENT OR PREVIOUS) YES ☐ NO ☐

a. INSURED'S DATE OF BIRTH MM DD YY SEX M ☐ F ☐

b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX M ☐ F ☐

b. AUTO ACCIDENT? YES ☐ NO ☐ PLACE (State)

b. EMPLOYER'S NAME OR SCHOOL NAME

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? YES ☐ NO ☐

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES ☐ NO ☐ *If yes*, return to and complete item 9 a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE: I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED _____ DATE _____

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE: I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED _____

14. DATE OF CURRENT: MM DD YY ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO MM DD YY

17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE

17a. I.D. NUMBER OF REFERRING PHYSICIAN

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO MM DD YY

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? YES ☐ NO ☐ $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE)

1. L290.__ 3. L____.__

2. L____.__ 4. L____.__

22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B Place of Service	C Type of Service	D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E DIAGNOSIS CODE	F $ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	I EMG	J COB	K RESERVED FOR LOCAL USE
1 01 01 06	01 01 06	11		H2036			200 00	1				
2												
3												
4												
5												
6												

25. FEDERAL TAX I.D. NUMBER SSN ☐ EIN ☐

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES ☐ NO ☐

28. TOTAL CHARGE $ 200 00

29. AMOUNT PAID $

30. BALANCE DUE $ 200 00

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

A. Provider 1/1/06
SIGNED DATE

32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)

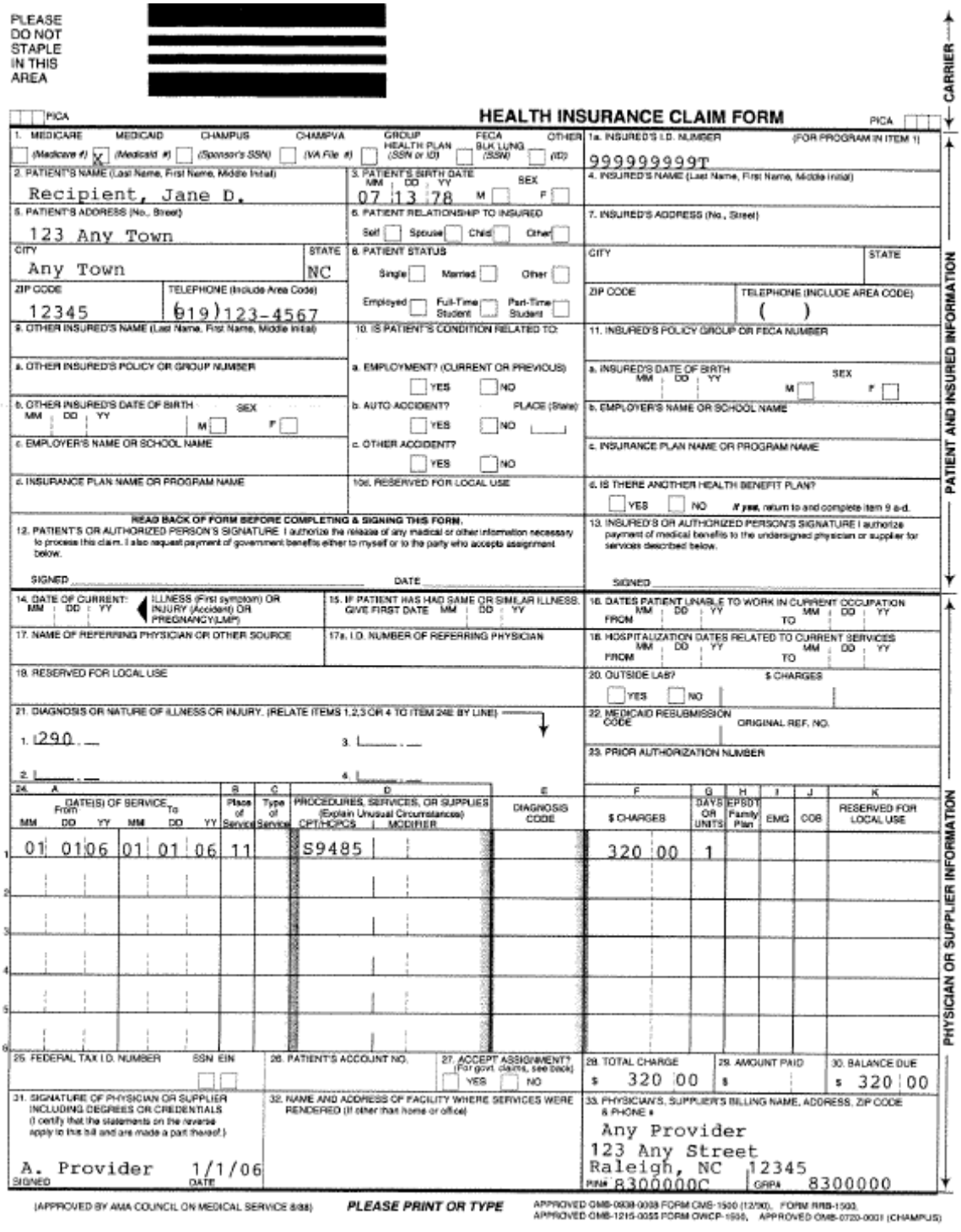
33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #

Any Provider
123 Any Street
Raleigh, NC 12345
PIN# 8300000U GRP# 8300000

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8/88) **PLEASE PRINT OR TYPE** APPROVED OMB-0938-0008 FORM CMS-1500 (12/90), FORM RRB-1500, APPROVED OMB-1215-0055 FORM OWCP-1500, APPROVED OMB-0720-0001 (CHAMPUS)



PLEASE DO NOT STAPLE IN THIS AREA

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PICA

HEALTH INSURANCE CLAIM FORM

PICA

CARRIER

1. MEDICARE (Medicare #) | MEDICAID (Medicaid #) X | CHAMPUS (Sponsor's SSN) | CHAMPVA (VA File #) | GROUP HEALTH PLAN (SSN or ID) | FECA BLK LUNG (SSN) | OTHER (ID)

1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1): 999999999T

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): Recipient, Jane D.

3. PATIENT'S BIRTH DATE MM DD YY: 07 13 78 SEX M F

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No., Street): 123 Any Town

6. PATIENT RELATIONSHIP TO INSURED: Self | Spouse | Child | Other

7. INSURED'S ADDRESS (No., Street)

CITY: Any Town STATE: NC

8. PATIENT STATUS: Single | Married | Other; Employed | Full-Time Student | Part-Time Student

CITY STATE

ZIP CODE: 12345 TELEPHONE (Include Area Code): (919)123-4567

ZIP CODE TELEPHONE (INCLUDE AREA CODE) ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (CURRENT OR PREVIOUS) YES NO

a. INSURED'S DATE OF BIRTH MM DD YY SEX M F

b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX M F

b. AUTO ACCIDENT? YES NO PLACE (State)

b. EMPLOYER'S NAME OR SCHOOL NAME

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? YES NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES NO If yes, return to and complete item 9 a-d.

PATIENT AND INSURED INFORMATION

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE. I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED _____ DATE _____

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED _____

14. DATE OF CURRENT: MM DD YY ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO

17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE

17a. I.D. NUMBER OF REFERRING PHYSICIAN

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? YES NO $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE)

1. L290.__ 3. L___.__

2. L___.__ 4. L___.__

22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

PHYSICIAN OR SUPPLIER INFORMATION

24. A DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B Place of Service	C Type of Service	D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E DIAGNOSIS CODE	F $ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	I EMG	J COB	K RESERVED FOR LOCAL USE
1 01 01 06	01 01 06	11		S9485			320 00	1				
2												
3												
4												
5												
6												

25. FEDERAL TAX I.D. NUMBER SSN EIN

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES NO

28. TOTAL CHARGE $ 320 00

29. AMOUNT PAID $

30. BALANCE DUE $ 320 00

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

A. Provider 1/1/06

SIGNED DATE

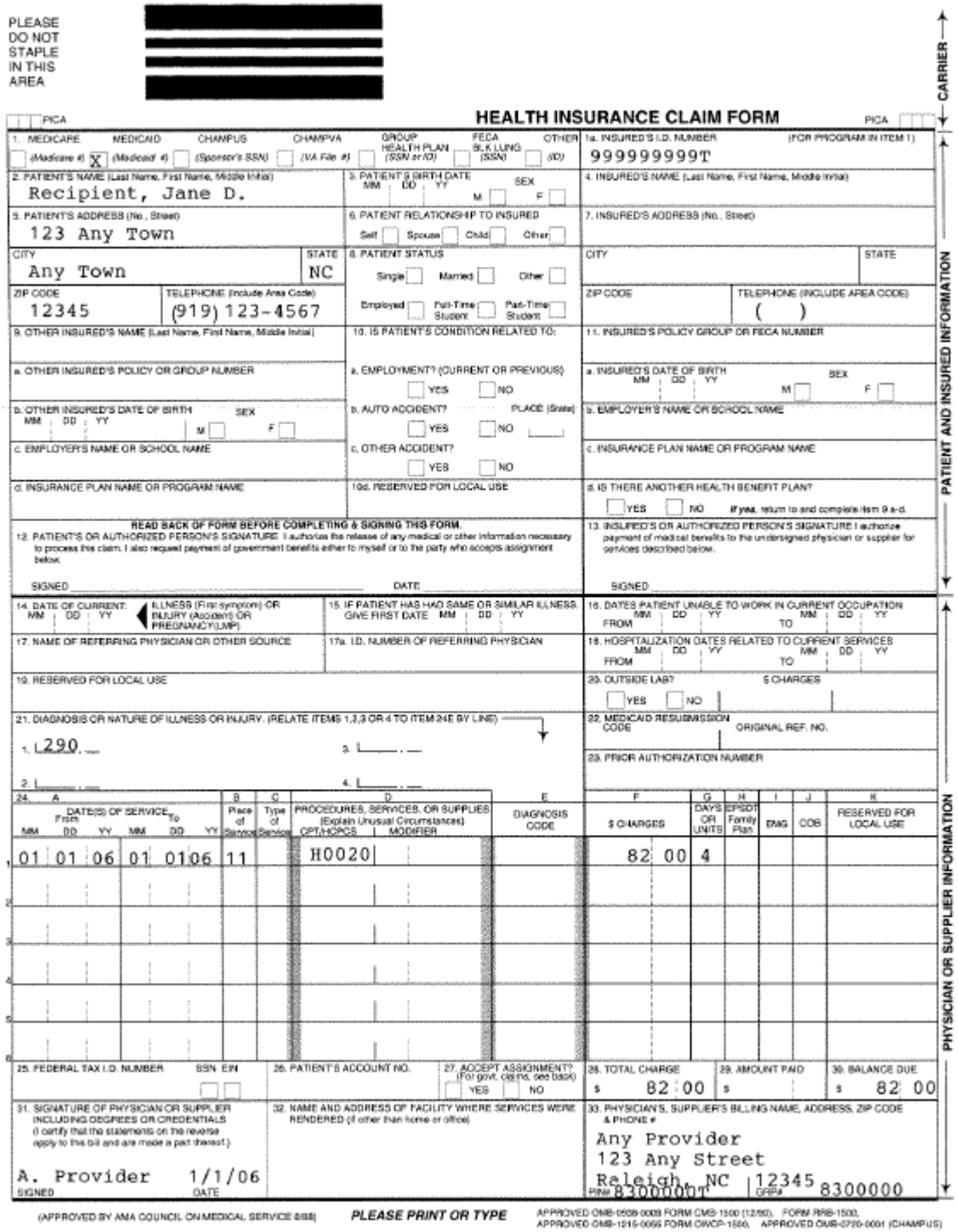
32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)

33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #

Any Provider
123 Any Street
Raleigh, NC 12345

PIN# 8300000C GRP# 8300000

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8/88) **PLEASE PRINT OR TYPE** APPROVED OMB-0938-0008 FORM CMS-1500 (12/90), FORM RRB-1500, APPROVED OMB-1215-0055 FORM OWCP-1500, APPROVED OMB-0720-0001 (CHAMPUS)



PLEASE DO NOT STAPLE IN THIS AREA

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PICA — **HEALTH INSURANCE CLAIM FORM** — PICA

CARRIER

1. MEDICARE (Medicare #) [X] MEDICAID (Medicaid #) CHAMPUS (Sponsor's SSN) CHAMPVA (VA File #) GROUP HEALTH PLAN (SSN or ID) FECA BLK LUNG (SSN) OTHER (ID)

1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1): 999999999T

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): Recipient, Jane D.

3. PATIENT'S BIRTH DATE MM DD YY SEX M F

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No., Street): 123 Any Town

6. PATIENT RELATIONSHIP TO INSURED: Self Spouse Child Other

7. INSURED'S ADDRESS (No., Street)

CITY: Any Town — STATE: NC

8. PATIENT STATUS: Single Married Other; Employed Full-Time Student Part-Time Student

CITY — STATE

ZIP CODE: 12345 — TELEPHONE (Include Area Code): (919) 123-4567

ZIP CODE — TELEPHONE (INCLUDE AREA CODE): ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (CURRENT OR PREVIOUS) YES NO

a. INSURED'S DATE OF BIRTH MM DD YY SEX M F

b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX M F

b. AUTO ACCIDENT? PLACE (State) YES NO

b. EMPLOYER'S NAME OR SCHOOL NAME

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? YES NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES NO If yes, return to and complete item 9 a-d.

PATIENT AND INSURED INFORMATION

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED _____ DATE _____

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED _____

14. DATE OF CURRENT: MM DD YY — ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO MM DD YY

17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE

17a. I.D. NUMBER OF REFERRING PHYSICIAN

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO MM DD YY

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? YES NO $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE)

1. 290.__ 3. ____.__

2. ____.__ 4. ____.__

22. MEDICAID RESUBMISSION CODE — ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

PHYSICIAN OR SUPPLIER INFORMATION

24. A DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B Place of Service	C Type of Service	D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E DIAGNOSIS CODE	F $ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	I EMG	J COB	K RESERVED FOR LOCAL USE
1 01 01 06	01 01 06	11		H0020			82 00	4				
2												
3												
4												
5												
6												

25. FEDERAL TAX I.D. NUMBER SSN EIN

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES NO

28. TOTAL CHARGE $ 82 00

29. AMOUNT PAID $

30. BALANCE DUE $ 82 00

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

A. Provider 1/1/06

SIGNED DATE

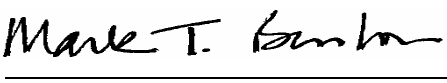
32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (if other than home or office)

33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #

Any Provider
123 Any Street
Raleigh, NC 12345

PIN# 8300000T GRP# 8300000

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8/88) **PLEASE PRINT OR TYPE** APPROVED OMB-0938-0008 FORM CMS-1500 (12/90), FORM RRB-1500, APPROVED OMB-1215-0055 FORM OWCP-1500, APPROVED OMB-0720-0001 (CHAMPUS)



Mark T. Benton, Senior Deputy Director and
Chief Operating Officer
Division of Medical Assistance
Department of Health and Human Services

Cheryll Collier
Executive Director
EDS